

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1800 Bienville Drive
Monroe, LA 71201-3765
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

*Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).*

Date of Request:*	Number of Fax Pages:*
Practitioner Information	Patient Information
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth (m/d/y):*
Call-Back Phone Number (include area code):*	
Fax Number (include area code):*	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

- Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO
- Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
If YES, list the condition(s) in the box below:
- Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
If YES, list the interaction(s) in the box below:
- Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
If YES, list the side effects in the box below:

Practitioner Signature:* _____

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

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